MINUTES
of the
FIRST MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

July 9, 2013
Eastern New Mexico University, Campus Union Building, Multi-Purpose Room 110
43 University Blvd.
Roswell

The first meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Benny Shendo, Jr., chair, on July 9, 2013 at 10:16 a.m. in Multi-Purpose Room 110 in the Campus Union building on the campus of Eastern New Mexico University (ENMU) in Roswell.

Present
Sen. Benny Shendo, Jr., Chair
Rep. Stephen Easley, Vice Chair
Rep. Phillip M. Archuleta
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Gay G. Kernan
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent
Sen. Sue Wilson Beffort
Sen. Howie C. Morales
Sen. Sander Rue

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written testimony are in the meeting file.

Tuesday, July 9

Introductions

Senator Shendo asked members and staff to introduce themselves.

Welcome

Dr. John Madden, president of ENMU, welcomed the subcommittee and described the university as a community of 4,000 to 5,000 students enrolled in a wide range of degree and certificate academic programs, including a special services program for the disabled and one of the only air traffic control programs in the United States. (See handout.)

Update from the New Mexico Rehabilitation Center

Janie Davies, administrative services director of the New Mexico Rehabilitation Center (NMRC), told the subcommittee about NMRC's Chemical Dependency Unit, which provides addiction treatment. The program, she explained, is not an intensive one-on-one program. (See handouts.) It lasts 21 days, and "there is only so much we can do" during that time period. There is one psychiatrist and multiple facilitators on staff. The program works with other interventions of the patient's choosing, such as Alcoholics Anonymous, Narcotics Anonymous and other faith-based programs.

There are 43 beds at the NMRC; 15 in the medical wing and 28 in the chemical dependency wing. Most admissions — at least 80% — are court-ordered, the majority coming from Albuquerque. Ms. Davies said that many court-ordered admittees have a negative attitude at first, but they show appreciation for the program after three weeks. Individuals who have not had a job in 10 years because of chemical dependence are able to focus for the first time, and they do not want to be there. Included in her handouts is a copy of the letter that admittees have to sign.

Ms. Davies stated that the NMRC treats an average of 18 to 20 individuals who are admitted to the substance abuse treatment program every day. The program must accept all court-ordered admittees but screens other applicants for admission to ensure that the individuals have already gone through withdrawal. Team conference happens once a week with doctors and counselors and a progress report is completed for each client.

Questions/Concerns

Funding source. The NMRC's chemical dependency program uses about $2.5 million in Department of Health (DOH) general fund dollars. The staff at the NMRC are all DOH employees. However, the NMRC accepts reimbursement from private payers as well. The chemical dependency program is currently not eligible for reimbursement through Medicare or Medicaid. It has not been able to meet the staffing or facility requirements under those programs but is "actively working" toward certification. As of July 1, it employs a psychiatrist. It is difficult, Ms. Davies explained, to obtain the staff the facility needs, such as psychiatrists, psychiatric nurse practitioners and registered nurses. The NMRC provides services on a sliding-

fee scale for everyone who walks through the door, accepting county indigent funding and private insurance and Medicaid. Anyone of either sex over the age of 18 may be admitted.

Population treated in the Chemical Dependency Unit. The unit accepts all addictions, though it cannot offer suboxone/buprenorphine treatment and cannot admit patients who are recovering through these opioid-replacement therapies. Alcohol detoxification presents dangers, so the NMRC requires five days' withdrawal from alcohol before admission. Nurses are difficult to hire, and detoxification is not feasible at the NMRC.

Post-release follow-up. The NMRC does 30-day, 60-day, 90-day and one-year follow-ups with patients, contacting them at telephone numbers they provide. However, many are not reachable later; many are admitted after being homeless; and most are from outside the Roswell area. It is difficult to gauge the success of the individuals because there is no way to ascertain whether an interviewee is telling the truth over the telephone.

Evidence-based therapy. The NMRC uses a "conglomeration" of approaches, including faith-based and 12-step programs; patients need to be in a support group. A patient chooses the approach the patient will take.

Discussion of chemical dependency treatment facilities in New Mexico. Ms. Davies stated that she knows of only three inpatient chemical dependence treatment facilities in the state. She said she believes that the DOH's Turquoise Lodge will be opening an entire wing for adolescent chemical dependence. Fort Bayard has a small program. She said that if the NMRC had the option, it would expand to offer intensive outpatient therapy. The NMRC also could use an outpatient program through counseling associations to provide support to those back in the community. This would allow the NMRC to serve more people more effectively.

In rural and semi-rural areas of the state such as Roswell, it is difficult to find the personnel necessary to staff many facilities. The Los Lunas facility is a state facility, but it does not provide chemical dependence therapy. For detoxification, patients in Roswell will be sent to Sunrise at the ENMU Medical Center. The NMRC does not provide outreach counseling after discharge. It does have a list of resources throughout the state to provide to patients upon discharge, connecting them with the NMRC and with Narcotics Anonymous and Alcoholics Anonymous. The number of repeat admittees fluctuates greatly, according to Ms. Davies, and the rate of recidivism is high. A subcommittee member observed that, with at least one-third of the patients coming from Albuquerque, the legislature may wish to expand the chemical dependency treatment resources that are available in the Albuquerque area.

Working with Native American people. The NMRC treats many Native American patients. Often tribal governments support the cost of care. Those individuals who have the support of their tribes in recovery will have the most success, Ms. Davies said. As patients direct the type of care that they receive, it depends on the patient whether they receive care that is aligned with a particular cultural heritage. There was discussion about the closure of the Nizhoni Center, an

important chemical dependency treatment facility in Gallup. It was observed that the need for such programs is great and resources are few.

Panel: Community-Based Behavioral Health

Jane Batson, interim assistant vice president for external affairs at ENMU, informed the subcommittee that she has been working with a large group to address homelessness. (See handout.) In 2011 and in 2012, the group has used point-in-time surveys to identify homeless people, which has been done routinely in Albuquerque. This has provided an idea of the number of homeless people in the area. These numbers have increased in the past few years, though housing has not kept up with demand. The group found that people living with disabilities are twice as likely as non-disabled individuals to be living in homeless shelters. At least 40% of these individuals are likely to have a mental illness or chemical dependence issue.

Ms. Batson shared her and her group's disappointment that the state-owned rehabilitation facility, which has been abandoned by the NMRC, was not made available for homeless services. The group had assembled a large coalition of agencies that intended to establish a nonprofit to provide services for homeless people. The coalition had been in negotiations with the Martinez Administration, but were then informed that a donation of the NMRC facility would violate the Anti-Donation Clause of the Constitution of New Mexico. The building has now been condemned and destroyed.

Questions/Concerns for Ms. Batson

Youth services. The Roswell nonprofit, Assurance Home, operates the James Ranch Youth Shelter, which provides housing and support for teens, including short-term homeless housing for teenagers, with a capacity to serve 20 individuals, Ms. Batson said. It is funded by the Children, Youth and Families Department (CYFD), and private funding flows through Assurance Home and other donations. It is co-educational, with an even male-to-female ratio. The facility is always full, with "extras" sleeping on sofas. The majority served are homeless adolescents under 19 years of age who have conflicts at home. They may have been living in tents, boxes and on the streets for a time. Many end up in a CYFD home for children who cannot be placed in foster homes. They are primarily from Chaves County.

New Mexico has the second-highest rate of child homelessness in the country, Ms. Batson said. It is a problem afflicting both rural and urban areas. Children at the James Ranch Youth Shelter go to school in the Roswell Independent School District. They have counselors and activities. The children remain at the shelter, which is supported by a foundation and operated by Assurance Home, for 30 to 45 days.

There was further discussion about the dearth of facilities to accommodate homeless youth in the state.

Anti-Donation Clause. Some subcommittee members suggested that a constitutional amendment to provide for easier state support of nonprofit welfare activities may be in order.

Some of the exceptions to the Anti-Donation Clause, including welfare purposes, were discussed.

Jessie Chavez, a former state liaison to Local Behavioral Health Collaboratives 5, 9, 10 and 12, next addressed the subcommittee. (See handouts.) Mr. Chavez explained that local collaboratives are a way for localities to provide input in the behavioral health system statewide. Members are people receiving behavioral health services, family members of consumers, providers, public education and law enforcement — whoever is involved in behavioral health services in the state. Mr. Chavez discussed the history of the collaboratives.

According to Mr. Chavez, local collaboratives are able to obtain total-community-approach funding for youth substance abuse prevention and treatment. He discussed intensive outreach programs through schools and elsewhere. Reports show a significant improvement among participants, as compared to nonparticipant teens. This work has had an impact on teen drug use. Local Collaborative 5 members realized suicide is a big issue. They developed a subcommittee of the local collaborative to work with teens in high schools. The school system, Counseling Associates, Inc., (CA) and others developed an approach based on *More Than Sad* videos. Local collaborative members went into high school freshmen health classes to provide suicide prevention training. The group consisted of independently licensed providers, who used video and discussions. Local Collaborative 3 has exported this intervention model to other collaboratives.

Mental health first-aid training. Mr. Chavez explained that this program provides "first aid" to individuals having a mental health crisis. It is intended for use by service employees who may come across people in mental health crises. It provides a protocol that may serve as a more helpful alternative than calling the police to intervene.

Local collaboratives have the umbrella of LifeLink in Santa Fe. Thus, they are able to provide members' travel, training and related expenses. Affordable housing has disappeared, according to Mr. Chavez. "We had some federal funding; 24 units in Eddy county," he said, "but costs have increased: $2.3 million needed and $1.8 million found". Roosevelt and Curry counties' Local Collaborative 9 has been doing work with core service agencies to provide anti-stigma (for receiving mental health services) awareness and fundraising. Local Collaborative 12, in Lincoln and Otero counties, has been focused on consumer involvement and has established hotlines for people to call when someone is in crisis. Local Collaborative 10 in De Baca, Quay and Harding counties cites a lack of adequate transportation, a lack of services and a lack of professionals to serve its population.

Questions/Concerns

Gangs in Chaves County. Mr. Chavez stated that gangs continue to present a challenge in Chaves County, although the incidence of gang-related activity has decreased in recent years. Several community groups have become involved, and programs have been established to provide mentoring, a youth center and community gardens. There also are programs that

promote collaboration between seniors and youths, an intergenerational connection that Mr. Chavez stated seems to be dissolving in society.

Collaborative functions. Mr. Chavez stated that local collaboratives have no involvement with monitoring expenditures of behavioral health funds. The Interagency Behavioral Health Purchasing Collaborative (IBHPC) is operated by state agency executives, he noted, and it is supposed to be looking at utilization and providing oversight.

A subcommittee member stated that the statewide behavioral health entity, OptumHealth of New Mexico, and the IBHPC have failed in their responsibilities.

Marti Wright Everitt, chief executive officer of CA, next made her presentation. (See handout.) She stated that CA provides behavioral health services in Chaves and Eddy counties. The landscape has greatly shifted recently, said Ms. Everitt, with the decision of the Human Services Department (HSD) to issue a pay hold against several behavioral health service provider entities whom it has accused of fraud. "CA's offices will be closed within the next two weeks unless something happens", she stated.

Ms. Everitt informed the subcommittee that she has been a resident of Roswell for 34 years and has served as director for CA for the past 27 years. CA provides behavioral health services to more than 4,000 individuals each year who are the most needy and vulnerable — adults, young mothers, homeless and at-risk people. Ms. Everitt said that she and 14 of her colleagues, plus 204 employees, have been branded by the HSD as criminals and liars. Ms. Everitt stated that this is untrue and that the HSD's fraud investigation is an "erroneous, dubious and fundamentally flawed process". Since 1996, CA has contracted with managed care organizations (MCOs) that the state has designated, changing every four years to work with a new MCO. Since 1996, there have been four different MCOs, with differing rules and expectations and "non-working billing and payment systems", she stated. The new Medicaid waiver program, Centennial Care, will be another change, with four separate MCOs to deal with at once. The state's public behavioral health system is, in Ms. Everitt's opinion, "chaotic, inconsistent [and] administratively overburdened" and will collapse under its own weight. She stated that she partly believes that the HSD is, in fact, intending to start anew rather than fixing a "broken" system. CA has had to pass rigorous audits repeatedly and has passed these audits and reviews at a 90% or 100% pass rate, she said. MCOs bring major problems around a billing system, and then refuse payment to providers for six months at a time or longer.

Ms. Everitt described what she characterized as many difficulties with OptumHealth and described a claims system that has "never worked", payment from incorrect payer sources and incorrect aberrant claims identification. One direct service provider agency gave her a stack of emails between OptumHealth and that agency regarding billing problems, and the stack she displayed appeared to be about six inches thick. Ms. Everitt stated that the HSD and OptumHealth failed to communicate effectively with provider entities about claims anomalies and published the names of the 15 provider entities. These provider entities have been told to

continue services without pay until Arizona provider entities take over management of the New Mexico provider entities' operations. CA did take the opportunity to submit a request for a lifting of the pay hold for "good cause". Ms. Everitt stated that Southwest Counseling would be closing and that the consequences would be "tragic" for thousands of consumers if the HSD does not lift pay holds imposed upon these provider entities.

The auditor employed by the HSD for the provider entity investigations is Public Consulting Group, Inc., (PCG) from Boston. PCG has audited programs in North Carolina, and Ms. Everitt reported that PCG had been placed on a corrective action plan in North Carolina due to complaints regarding its audit. North Carolina's state auditor found that PCG had committed great errors in its audit, Ms. Everitt said. Provider entities in North Carolina were allowed to address the deficiencies alleged in the audit. Ms. Everitt said that she questions the HSD's claim that it had no discretion but to turn over the alleged provider entity practices for criminal investigation immediately upon receiving PCG's audit results. Ms. Everitt stated that she wants the HSD to continue its investigation, but only after reestablishing payment to all of the provider entities. She also wants OptumHealth's software system to be investigated to ascertain the types of anomalies identified.

Questions/Concerns

HSD actions and PCG audit. Subcommittee members expressed a great deal of concern about the ongoing HSD fraud investigation and pay holds. They stated that medical recordkeeping is "not an exact science". Members questioned the speed with which the HSD turned over the PCG audit findings as "credible allegations of fraud" (CAFs) and what the federal regulations actually require. A member expressed frustration that a meeting with the HSD and the IBHPC had "gone nowhere", with the HSD refusing to reveal any information about the ongoing investigation and pay holds. It was suggested that PCG audit the Arizona provider entities before they take over.

Request to state auditor. Members suggested writing a letter to the state auditor requesting that he investigate the actions of the HSD, the IBHPC, PCG and OptumHealth, just as the North Carolina state auditor had. A motion was made and seconded, and the motion passed.

July 3 LHHS meeting. Some members discussed the July 3 meeting of the LHHS in Albuquerque. Secretary of Human Services Sidonie Squier, IBHPC Director Diana McWilliams and Attorney General (AG) Gary King were all present. Secretary Squier was questioned about the hiring of PCG through a "single-source contract" and her claims that referral to the AG was required upon the CAF finding. Yet, a member argued, the HSD had the discretion to make a CAF finding, and nothing required the HSD to make a CAF finding within four days of receiving the results of the PCG audit.

A member stated that AG King had expressed disagreement with Secretary Squier at the July 3 hearing, in that he had made no determination of fraud whatsoever, that the CAF was

made by the HSD, but a determination of fraud in the criminal or civil sense could only be made after the AG had had an opportunity to investigate each case.

PCG's audit in North Carolina. A subcommittee member raised several issues regarding what the member had learned about PCG's audit in North Carolina. PCG was paid something in excess of $2 million. Its earnings were contingent upon the amount of fraud PCG reported, even if none of that alleged fraud was substantiated. Thus, PCG had an incentive to overreport allegations of fraud. The member wondered whether the HSD's contract with PCG had similar provisions for contingency.

Discussion with Al Lama, assistant AG. Mr. Lama emphasized the distinction between a CAF and the AG's investigation of possible criminal or civil causes of action. He said that the CAF standard was an "easy threshold". Also, the HSD would face severe penalties for not complying with federal law. However, the HSD had the option of taking as much time as it needed to make a determination of CAF. The AG does not wish to disclose specific information regarding the fraud claims, as disclosure could prejudice the ongoing investigation and any prosecution. Mr. Lama could not give a date when the review of the 15 agencies will be complete; maybe a couple of months, but in these cases, he said, it may take up to a year.

Panel Discussion: Legislative Finance Committee (LFC) Program Evaluation of Behavioral Health Services 2013

Charles Sallee, deputy director, LFC, and Pam Galbraith and Valerie Crespin-Trujillo, LFC program investigators, presented the results of their LFC report to the subcommittee. (See handouts.) Mr. Sallee began the presentation by discussing challenges due to substance abuse. He stated that in New Mexico, prescription drug deaths now exceed deaths due to illicit drugs. Eight of the 10 leading causes of death in New Mexico are at least partially due to substance abuse. Thirty percent of adults receiving services in New Mexico's behavioral health system have co-occurring disorders. Many young people face depression and other mental distress. Maternal depression has an effect upon the cognitive development of youths.

The panel discussed the statutory history and duties of the IBHPC and the Behavioral Health Planning Council, a large advisory body to the IBHPC. The IBHPC is charged in statute with contracting with one or more behavioral health service MCOs. The IBHPC contracted with ValueOptions to serve as the statewide entity (SE), and, later, with the current SE, OptumHealth.

Mr. Sallee reported that the IBHPC is supposed to, but does not, provide a master plan yearly and that reporting provided by the IBHPC is not of good quality and does not allow a real assessment of behavioral health service needs in the state. It is almost impossible to reconcile OptumHealth and HSD reporting. Moreover, the IBHPC has not used the rulemaking authority it has been provided in statute. This rulemaking was supposed to be the mechanism to provide a responsive framework for behavioral health services and an inventory of all behavioral health expenditures.

Before the IBHPC was instituted, a series of agencies funded providers either directly or, as with the HSD, through a third party. The DOH provided block grants to coordinating agencies. Mr. Sallee referred subcommittee members to the LFC report at page 10, which shows how the SE was another layer added to pull together the diverse behavioral health service purchasing among state agencies. The HSD now spends the vast majority of behavioral health dollars. Most of the CYFD behavioral health services funding flows through OptumHealth, but not all of it.

Questions/Concerns

IBHPC reporting. Ms. Crespin-Trujillo addressed the discrepancies between HSD and IBHPC reporting. OptumHealth reporting is often aggregated, she explained. Sometimes data regarding adults are not separated from those pertaining to children, and a reviewer must sift through "layers" of data. Also, there is a lag in paying claims that exists throughout Medicaid: fiscal year (FY) 2012 claims may not be paid until 2013.

A subcommittee member observed that a lack of consistency in reporting is an effective way of obfuscating information. Mr. Sallee stated that the LFC has been raising the "red flag" on the lack of transparency for a number of years.

Nonpayment of direct service providers. Many complaints have been made about SEs failing to pay providers or failing to pay them in a timely fashion. At one time, MCOs had paid only 50% of allotted funds to direct service providers and had failed to provide a proper accounting for how that money flowed. A subcommittee member stated that OptumHealth has yet to settle many of these complaints. Another member observed that problems with financial oversight of public behavioral health expenditures continue, and changes for accountability are still needed.

Mr. Sallee stated that there is almost no systematic approach by the SE or others to find large-scale Medicaid waste, fraud and abuse. Instead, the HSD's Office of Inspector General (OIG) has concentrated on prosecuting allegations of fraud by individual recipients for small dollar amounts. The HSD has recently decided to issue the HSD's OIG report directly to the secretary. The LFC recommends that this reporting role be codified to allow greater independence. Mr. Sallee mentioned Senator John M. Sapien's 2013 Senate Bill 227 (which did not pass) and the State Inspector General Act, which would strengthen the LFC's and state agencies' ability to perform audits and investigations.

Ms. Crespin-Trujillo indicated that $56 million of the behavioral health budget of $283 million comes from state general funds and federal grant dollars, not from Medicaid dollars. This $56 million serves 24,000 residents.

There was discussion of what was characterized as a lack of authority and administration at the HSD for behavioral health services and a "convoluted system" for consumers and providers. Mr. Sallee stated that it is not possible for the IBHPC, the HSD or the legislature to

analyze which services are helping consumers and which are not. He reported that contract services comprise a majority of the behavioral health budget (provider reimbursement for patient services and administrative fees for OptumHealth). Expenditures have increased, as have the units of services, while the number of individuals served has recently declined from 25,000 to 22,500. OptumHealth characterized more than $1 million in FY 2010 through FY 2012 as "uncategorized". Thus, the HSD does not have the information it needs to monitor services. Performance outcomes have been inconsistent for the past three years. There has not been adequate follow-up after discharge of patients in chemical dependency treatment programs.

Provider audits. Ms. Galbraith said that the LFC performed its behavioral health services program evaluation before the PCG audit's completion. She referred the subcommittee to page 28 of the LFC report, which indicates that OptumHealth and the HSD's OIG are responsible for reviewing program integrity. The HSD's OIG is obligated to audit providers. OptumHealth is paid consideration in its contract with the HSD to do so. Program integrity efforts by the OIG and OptumHealth, according to Ms. Galbraith, should have served as an early warning system for the pending crisis brought about by the PCG audit of the 15 providers. In none of the information received by the LFC investigators, Ms. Galbraith said, was there evidence of any audit performed by the HSD's OIG or by OptumHealth. She stated that the LFC staff performing the behavioral health services audit made a "considerable" number of information requests to OptumHealth. She referred the subcommittee to page 29 of the LFC report.

Ms. Galbraith said that the LFC program evaluation team had difficulty obtaining responses from the HSD during its audit. The team had planned to go into provider agencies, review client files, compare claims processing with documentation of services delivered and examine the providers' use of evidence-based practices, but the HSD claimed that providing LFC staff access to this information would violate federal law — namely, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HSD claimed that, under HIPAA, a "health oversight agency" could have access, but the LFC does not constitute a health oversight agency. The HSD disagrees with LFC staff that a health care funding agency such as the LFC should be accorded access under the HIPAA Privacy Rule. The LFC never did obtain the information requested. Referring members to page 23 of the LFC report, Ms. Galbraith said that the program integrity clause of the HSD's contract with OptumHealth is weak, lacking performance measures by which the HSD can evaluate monitoring effectiveness.

Ms. Galbraith observed that behavioral health programs funded by state general fund dollars are "key" for individuals without other access to these services.

Letters of direction. Ms. Galbraith explained to subcommittee members the use of "letters of direction", which the IBHPC issued to the SE to direct how funds should be allocated. The IBHPC issued more than 170 letters of direction during the period under review. Ms. Galbraith stated that the letters of direction are intended to allow the IBHPC to direct the use of funds that had been allocated to the IBHPC but would revert if unused by the end of the fiscal year. The letters of direction direct the SE to do certain things and evade the state's Procurement Code,

which would have required a bid process. The LFC, she explained, believes this to be an illegal practice. Providers, pursuant to provider contracts, are obligated to support operational costs through contractual reimbursement. However, Ms. Galbraith explained, letters of direction allow the program to request reimbursement for a portion of operational costs. These practices raise concerns under the Constitution of New Mexico's Anti-Donation Clause. For example, in 2013, the AG found a violation when fair market rents were not being charged to nonprofits using buildings owned by the City of Las Cruces.

A member asked Mr. Lama to explain what sanctions apply to Anti-Donation Clause violations. Mr. Lama replied that the constitution provides no penalty. If public money is expended, there may be a responsibility to reimburse the general fund. There is no criminal or civil penalty. The AG may be responsible for recovery in cases of Anti-Donation Clause violations.

Questions/Concerns

Letters of direction. It was observed that these letters should be available through public records requests. Another subcommittee member stated that actions ordered through letters of direction should require approval as budget adjustment requests. There was an inquiry into the role of the federal government, which oversees grants that it makes. Ms. Galbraith stated that a significant amount of money is transferred through letters of direction and that the LFC has no idea how money is spent through these letters. Once the money moves to the SE, there is less transparency.

Gene Lovato, a former deputy secretary of the HSD, stated that federal acquisition regulations provide guidance as to how the grant must be evaluated. The state is provided far more authority over these grants than has been heretofore recognized. Mr. Lovato counseled the subcommittee to examine both the relevant federal waiver and federal acquisition regulations.

Contracting. A subcommittee member asked whether it is necessary for state agencies such as the HSD and DOH to contract for management services when there are capable people at these agencies. Ms. Galbraith observed that there is a common practice of contracting with many former agency employees, some of them performing tasks with which they had previously been charged as employees.

Combining behavioral health service and physical health service administration. Referring to slide 5 of the handout, a member asked whether the state was "going backwards" to the previous policies in place in the 1990s, during which behavioral health services were, in name, provided jointly with physical health services, yet administered separately. The member asked whether that previous Medicaid configuration worked well. Mr. Sallee answered that the 1990s configuration did not work out well, according to the 2002 gap analysis. The member asked why the HSD was going back to something that did not work, and how was Centennial Care established? Mr. Sallee explained that the Centennial Care policies were administrative decisions made by the HSD, and the questions as to whether these policies would be an

improvement would be good ones to ask the secretary of human services. Centennial Care will integrate behavioral and physical health care services at the payment and managerial levels, yet Mr. Sallee opined that integration should occur at the provider level and not at payment or managerial levels.

Procurement Code. A member asked whether the HSD had violated the Procurement Code by hiring PCG as an auditor through a "sole-source" contract without bidding. The member asked whether controls could be placed on such procurements to avoid sole-source contracting in such cases. Mr. Sallee stated that he would perform an analysis of state procurement law. Another member stated that the HSD's action in performing a Medicaid audit without using the state auditor might be a violation of state law. There was discussion of the limited emergency basis on which a state agency may seek emergency procurement. Justification is supposed to be made in writing. Mr. Sallee stated that no such justification has been found for the sole-source PCG audit contract.

PCG audit in North Carolina. A member urged that PCG's audit work in North Carolina be carefully reviewed. The North Carolina contract provided contingent payments that would reward PCG for each unsubstantiated finding of fraud. Even in the event that the allegations of fraud are not substantiated, PCG is paid by North Carolina for the unsubstantiated cases. The member asked whether New Mexico's contract with PCG contains an incentive to find fraud, such as North Carolina's contract provides. The member further noted that the HSD refused to attend today's hearing. Mr. Sallee told the subcommittee that the LFC would be analyzing the contract.

Public Comment

Lorraine Freedle, Ph.D., identified herself as a licensed independent social worker and a pediatric neuropsychologist. Her agency, TeamBuilders Counseling Services, Inc., (TeamBuilders), has been in a payment hold due to the HSD's CAF against it. Dr. Freedle said that the HSD has not permitted TeamBuilders to take corrective action to address the HSD's concerns and that the HSD has publicly branded the TeamBuilders' leadership as criminals. Dr. Freedle stated that the Arizona provider agencies that the HSD has brought in to assume management of agencies such as TeamBuilders have not been publicly vetted. According to Dr. Freedle, they are not licensed or certified to provide the services that TeamBuilders has been providing. Seventeen million dollars in taxpayer money will be used to pay Arizona provider agencies. Dr. Freedle and her husband, Shannon W. Freedle, started TeamBuilders 17 years ago and began serving people statewide. TeamBuilders has been a sole provider in many communities and has more than 650 employees and foster parents working with it. It regularly receives audits from state and private entities that have found no problems. OptumHealth has found TeamBuilders to be 95% compliant per its reviews. Dr. Freedle questions the new algorhithmic software OptumHealth put into use. She also questions the 24-point audit tool that PCG used, pursuant to which a 96% compliance is a failure. She questions PCG's conflict of interest and the system in which this has happened. Dr. Freedle urged that the HSD immediately approve TeamBuilders' request that the pay hold be lifted for good cause. She

believes that if the Medicaid fraud investigation process is legitimate, all provider agencies should meet the criteria for a good-cause suspension of the pay holds.

Patsy Romero, chief operations officer for Easter Seals El Mirador (ESEM), told the subcommittee that she also represents one of the 15 providers the HSD has identified as criminal and as civilly fraudulent. She stated that ESEM would furlough 120 employees in Raton and Taos (who earn $13.25 an hour) and that 273 at-risk children and families would not get services as of the day of the meeting. OptumHealth told ESEM that it is in contract violation if ESEM did not serve patients without pay and that OptumHealth would decertify ESEM. New Mexico has intergenerational challenges and "our communities do not want outsiders to serve them", Ms. Romero said. ESEM is not made up of frauds or "tricky" people. "We love our clientele, our employees and our communities."

Former Senator Timothy Z. Jennings spoke next, welcoming the subcommittee to Roswell. He requested that the subcommittee take a look at the job training center in Roswell, which, he said, needs to recruit more children from New Mexico; half of them come from out of state. He also brought subcommittee members' attention to the New Mexico Military Institute lottery scholarship, which provides excellent opportunities through allotments of $10,000 to $12,000 per recipient. Mr. Jennings stated that New Mexicans have "begged" for money for behavioral health services, and yet the HSD pays $3 million for people "to do nothing for it". Mr. Jennings observed that layers of management or contracting for behavioral health services involves each "layer" receiving 10% "off the top". CA has been here for as long as he can remember, Mr. Jennings said. It has picked up the pieces regardless of upheavals in the behavioral health system. The state provider infrastructure has weathered enormous policy changes with the changes in administrations, he said, and "one does not find reliable providers like this just anywhere". Mr. Jennings unfavorably compared Secretary Squier with former Secretary of Human Services Pamela Hyde, J.D., who, he said, appeared at every meeting of the LHHS, even when she strongly disagreed with members' statements. "She showed up, with the courage of her convictions. She did not avoid meetings", Mr. Jennings said. "It's a problem that no one from HSD has shown up for the subcommittee meeting today."

Bridges to Accessing Care: Experiences of the Developmental Disabilities and Mental Illnesses (DDMI) Project

Dr. Alya Reeve introduced herself as principal investigator for the "DDMI Report" on the continuum of services for individuals living with co-occurring developmental disabilities and mental illnesses. Dr. Reeve is a professor of psychiatry, neurology and pediatrics at the University of New Mexico Health Sciences Center. Panelists Kari Hendra, a family nurse practitioner for student health at ENMU, and Nathan Padilla, a licensed master social worker and clinical supervisor for La Familia Mental Health Services, also introduced themselves and echoed some of the comments that they, too, had found the work of these providers to be top-notch.

Ms. Hendra pointed out that health practitioners are never trained on how to bill. She

provided the subcommittee with background about student health care at ENMU, stating that typical consumers in ENMU's program are students with developmental delays, including some dually diagnosed individuals. Some are not diagnosed. ENMU estimates that it serves about 100 students per semester, who come from all over the country. About half of New Mexico students have Medicaid. Sometimes, students do not have the psycho-social skills to be on their own right away, she said, and the extreme stress of school can lead them to "self-medicate" with drugs and alcohol.

Mr. Padilla, who has a background as a drug and alcohol counselor, explained that the DDMI project was previously funded by ValueOptions and that it also received a grant through a state fund. The project is trying to meet the needs of patients who might not be verbal or able to articulate their needs, and it is intended to be a collegial consultation model to increase capacity in the community. There are telehealth sites in Taos, Shiprock, Farmington, Roswell and Silver City. Telehealth sessions are interspersed with in-person sessions, building trust through the latter. The values have been about support and valuing clinicians.

Questions/Concerns

Telehealth. Pursuant to a question, a panelist told the subcommittee that telehealth is used to counsel practitioners. The DDMI project provides in-person services for patients for the first visit, and thereafter, it uses telehealth. With their clientele, project practitioners feel it is important to establish trust in person. A particularly useful aspect of telehealth is teleprescribing, which allows patients access to prescriptions without driving long distances, as they have been previously required to do for in-person prescribing. Dr. Reeve said the DDMI project is taking precautions to ensure a secure internet connection that complies with privacy laws using a "telepresence" format such as Skype.

The meeting adjourned at approximately 5:30 p.m.